Uniform Medicaid and Uninsured Uncompensated Care Cost and Charge Report (UCCR) Hospital: Medicare Provider Number: Reporting Period From: Reporting Period To: UCCR Version: Contact Information Contact Person for this report: Contact Title: Contact Email: Contact Phone Number: Filling Date: Is the amount of the HSN assessment included as a cost in the CMS-2552 used to complete this report?

If yes, please report the amount here:

	SCHEDULE A: MASSHEALTH FEE-F	OR-SERVICE	(FFS) COST	rs					FILING DATE:	1/0/1900	
			()					UCCR Versi	on (Interim/Final):		0
	COMPUTATION OF MASSHEALTH FEE-FOR-	SEDVICE COST	· · ·			PROVIDER NAME:	0	20011 10101	(
	COMPORATION OF MASSIFEACTIFF ECTION	SERVICE COST	3			PROVIDER NUMBER:	•		REPORTING PERIOD:	FROM	4 /0 /4000
						PROVIDER NUMBER:	0		REPORTING PERIOD:	FROM:	1/0/1900
						Г				TO:	1/0/1900
Ln No.	COST CENTER DESCRIPTION	COSTS INCLUDING INTERNS & RESIDENTS (FROM 2552 WKSHT B PART I COL 24) (1)	OBSERVATION COST RECLASS (LINE 30 TO LINE 92) AND POST STEPDOWN COSTS (FROM WKSHT B -2 COL 4 LINES 54, 60, 89 & 90)	TOTAL COSTS (COL 1 + COL 2)	CHARGES (FROM 2552 WKSHT C PART I COL 8)	HOSPITAL COST TO CHARGE RATIOS (COL 3 / COL 4)	MASSHEALTH FFS INPATIENT CHARGES (6)	MASSHEALTH FFS I/P COSTS (COL 5 x COL 6 except lines 30-46) (7)	MASSHEALTH FFS OUTPATIENT CHARGES (8)	MASSHEALTH FFS O/P COSTS (COL 5 x COL 8) (9)	TOTAL MASSHEALTH. FFS I/P AND O/P COSTS (COL 7 + COL 9) (10)
	INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)			0		0.000		0		0	0
	Intensive Care Unit			0		0.000		0		0	0
	Coronary Care Unit			0		0.000		0		0	0
	Burn Intensive Care Unit			0		0.000		0		0	0
	Surgical Intensive Care Unit			0		0.000		0		0	0
	Other Special Care (specify)			0		0.000		0		0	0
40	Subprovider IPF			0		0.000		0		0	0
41	Subprovider IRF			0		0.000		0		0	0
42	Subprovider (specify)			0		0.000		0		0	0
43	Nursery			0		0.000		0		0	0
44	Skilled Nursing Facility			0		0.000		0		0	0
45	Nursing Facility			0		0.000		0		0	0
46	Other Long Term Care			0		0.000		0		0	0
	ANCILLARY SERVICE COST CENTERS				,	<u> </u>	1		·	· · · · · · · · · · · · · · · · · · ·	
50	Operating Room			0		0.000		0		0	0
	Recovery Room			0		0.000		0		0	0
	Labor Room and Delivery Room			0		0.000		0		0	0
	Anesthesiology			0		0.000		0		0	0
	Radiology-Diagnostic			0		0.000		0		0	0
	Radiology-Therapeutic			0		0.000		0		0	0
	Radioisotope			0		0.000		0		0	0
	Computed Tomography (CT) Scan			0		0.000		0		0	0
	Magnetic Resonance Imaging (MRI)			0		0.000		0		0	0
	Cardiac Catheterization Laboratory			0		0.000		0		0	0
	PBP Clinical Laboratory Services-Program Only			0		0.000		0		0	0
	Whole Blood & Packed Red Blood Cells			0		0.000		0		0	0
	Blood Storing, Processing, & Trans.			0		0.000		0		0	0
	Intravenous Therapy			0		0.000		0		0	0
	Respiratory Therapy			0		0.000		0		0	0
	Physical Therapy			0		0.000		0		0	0
	Occupational Therapy			0		0.000		0		0	0
	Speech Pathology			0		0.000		0		0	0
69	Electrocardiology			0		0.000		0		0	0
70	Electroencephalography			0		0.000		0		0	0
71	Medical Supplies Charged to Patients			0		0.000		0		0	0
72	Implantable Devices Charged to Patients			0		0.000		0		0	0
73	Drugs Charged to Patients			0		0.000		0		0	0
74	Renal Dialysis			0		0.000		0		0	0
75	ASC (Non-Distinct Part)			0	ļ	0.000		0		0	0
76	Other Ancillary (specify)			0	<u> </u>	0.000		0		0	0
	OUTPATIENT SERVICE COST CENTERS										
88	Rural Health Clinic			0		0.000		0		0	0

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	SCHEDULE A: MASSHEALTH FEE-F	OR-SERVICE	E (FFS) COST	S					FILING DATE:	1/0/1900	
								UCCR Versi	on (Interim/Final):		0
	COMPUTATION OF MASSHEALTH FEE-FOR-	SERVICE COS	TS			PROVIDER NAME:	0				
					F	PROVIDER NUMBER:	0		REPORTING PERIOD:	FROM:	1/0/1900
										TO:	1/0/1900
Ln No.	COST CENTER DESCRIPTION	COSTS INCLUDING INTERNS & RESIDENTS (FROM 2552 WKSHT B PART I COL 24) (1)	OBSERVATION COST RECLASS (LINE 30 TO LINE 92) AND POST STEPDOWN COSTS (FROM WKSHT B -2 COL 4 LINES 54, 60, 89 & 90)	TOTAL COSTS (COL 1 + COL 2)	CHARGES (FROM 2552 WKSHT C PART I COL 8) (4)	HOSPITAL COST TO CHARGE RATIOS (COL 3 / COL 4)	MASSHEALTH FFS INPATIENT CHARGES (6)	MASSHEALTH FFS I/P COSTS (COL 5 x COL 6 except lines 30-46) (7)	MASSHEALTH FFS OUTPATIENT CHARGES (8)	MASSHEALTH FFS O/P COSTS (COL 5 x COL 8)	TOTAL MASSHEALTH. FFS I/P AND O/P COSTS (COL 7 + COL 9) (10)
	INPATIENT ROUTINE SERVICE COST CENTERS										
89	Federally Qualified Health Center			0		0.000		0		0	0
	Clinic			0		0.000		0		0	0
91				0		0.000		0		0	0
92	Observation Beds (see instructions)			0		0.000		0		0	0
93	Other Outpatient Service (specify)			0		0.000		0		0	0
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis			0		0.000		0		0	0
95	Ambulance Services			0		0.000		0		0	0
96	Durable Medical Equipment-Rented			0		0.000		0		0	0
97	Durable Medical Equipment-Sold			0		0.000		0		0	0
98	Other Reimbursable (specify)			0		0.000		0		0	0
99	Outpatient Rehabilitation Provider (specify)			0		0.000		0		0	0
100	Intern-Resident Service (not appvd. tchng. prgm.)			0		0.000		0		0	0
101	Home Health Agency			0		0.000		0		0	0
	SPECIAL PURPOSE COST CENTERS		•								
105	Kidney Acquisition			0		0.000		0		0	0
106	Heart Acquisition			0		0.000		0		0	0
107	Liver Acquisition			0		0.000		0		0	0
108	Lung Acquisition			0		0.000		0		0	0
109	Pancreas Acquisition			0		0.000		0		0	0
110	Intestinal Acquisition			0		0.000		0		0	0
111	Islet Acquisition			0		0.000		0		0	0
	Other Organ Acquisition (specify)			0		0.000		0		0	0
115	Ambulatory Surgical Center (Distinct Part)			0		0.000		0		0	0
116	Hospice			0		0.000		0		0	0
117	Other Special Purpose (specify)			0	<u> </u>	0.000		0	<u> </u>	0	0
118	SUBTOTAL (sum of lines 30-117)	0	0	0	0		0	0	0	0	0
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										
191	Research										
192	Physicians' Private Offices										
193	Nonpaid Workers										
194	Other Nonreimbursable (specify)										
200	Cross Foot Adjustments										
201	Negative Cost Centers										

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	SCHEDULE B: ROUTINE COST CENT	ER PER DIEMS	5							FILING DATE:	1/0/1900	
									UCCR Ver	sion (Interim/Final):	0	
	COMPUTATION OF ROUTINE COST CENTER	R PER DIEMS						PROVIDER NAME:	0			
								PROVIDER NUMBER:	0		FROM:	1/0/1900
											TO:	1/0/1900
	COST CENTER DESCRIPTION	TOTAL COSTS (COL 3 OF SCHEDULE A)	TOTAL PATIENT DAYS (WS S -3 PART I COL 8)	PER DIEM (COL 1 / COL 2)	FFS PATIENT DAYS	FFS INPATIENT COSTS (COL 3 x COL 4)	MMCO PATIENT DAYS	MMCO INPATIENT COSTS (COL 3 x COL 6)	HSN & UNINSURED CARE PATIENT DAYS	HSN & UNINSURED CARE INPATIENT COSTS (COL 3 x COL 8)	DUAL-ELIGIBLE PATIENT DAYS	DUAL-ELIGIBLE INPATIENT COSTS (COL 3 x COL 10)
Ln No.		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	0		0.00		0		0		0		0
31	Intensive Care Unit	0		0.00		0		0		0		0
32	Coronary Care Unit	0		0.00		0		0		0		0
33	Burn Intensive Care Unit	0		0.00		0		0		0		0
34	Surgical Intensive Care Unit	0		0.00		0		0		0		0
35	Other Special Care (specify)	0		0.00		0		0		0		0
40	Subprovider IPF	0		0.00		0		0		0		0
41	Subprovider IRF	0		0.00		0		0		0		0
42	Subprovider (specify)	0		0.00		0		0		0		0
43	Nursery	0		0.00		0		0		0		0
44	Skilled Nursing Facility	0		0.00		0		0		0		0
45	Nursing Facility	0		0.00		0		0		0		0
46	Other Long Term Care	0		0.00		0		0		0		0
	TOTAL PATIENT DAYS		0		0		0		0		0	

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	COLLEGE OF PAED TOWN PAGE (PARAGO)	LICNI O LIN	INCLIDED 0	DUAL FLICIBL	FOOCTC							
-	SCHEDULE C: MEDICAID MCO (MMCO),	HSN & UN	INSURED &	DUAL-ELIGIBL	E COSTS							
	COMPUTATION OF MASSACHUSETTS MEDICAID M	ICO AND LOV	V INCOME UNC	OMPENSATED CA	RE COSTS							
	COST CENTER DESCRIPTION	HOSPITAL COST TO CHARGE RATIOS (SCH A COL 5)	MASS. MMCO INPATIENT CHARGES	MASS. MMCO INPATIENT COSTS (COL 1 x COL 2 except lines 30 - 46)	MASS. MMCO OUTPATIENT CHARGES	MASS. MMCO OUTPATIENT COSTS (COL 1 x COL 4)	TOTAL MASS. MMCO I/P AND O/P COSTS (COL 3 + COL 5)	HSN & UNINSURED CARE INPATIENT CHARGES	HSN & UNINSURED INPATIENT COSTS (COL 1 x COL 7 except lines 30 - 46)	HSN & UNINSURED CARE OUTPATIENT CHARGES	HSN & UNINSURED CARE OUTPATIENT COSTS (COL 1 x COL 9)	TOTAL HSN & UNINSURED CARE COSTS (COL 8 + COL 10)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Ln No.			(2)		(4)		i i	(//	i i	(9)	i i	i
30	Adults and Pediatrics (General Routine Care)	0.000		0		0	0		0		0	0
31	Intensive Care Unit	0.000		0		0	0		0		0	0
32	Coronary Care Unit	0.000		0		0	0		0		0	0
33	Burn Intensive Care Unit	0.000		0		0	0		0		0	0
34	Surgical Intensive Care Unit	0.000		0	 	0	0		0	 	0	0
35	Other Special Care (specify)	0.000		0		0	0		0		0	0
40	Subprovider IPF	0.000		0	-	0	0		0	-	0	0
41	Subprovider IRF	0.000		0	-	0	0		0		0	0
42	Subprovider (specify)	0.000		0		0	0		0		0	0
43	Nursery	0.000		0		0	0		0		0	0
44	Skilled Nursing Facility	0.000		0		0	0		0		0	0
45	Nursing Facility	0.000		0	1	0	0		0	1	0	0
46	Other Long Term Care	0.000		0		0	0		0		0	0
<u> </u>	ANCILLARY SERVICE COST CENTERS						T I				ı	ı
50	Operating Room	0.000		0		0	0		0		0	0
51	Recovery Room	0.000		0		0	0		0		0	0
52	Labor Room and Delivery Room	0.000		0	1	0	0		0	1	0	0
53	Anesthesiology	0.000		0	1	0	0		0	1	0	0
54	Radiology-Diagnostic	0.000		0		0	0		0		0	0
55	Radiology-Therapeutic	0.000		0		0	0		0		0	0
56	Radioisotope	0.000		0		0	0		0		0	0
57	Computed Tomography (CT) Scan	0.000		0		0	0		0		0	0
58	Magnetic Resonance Imaging (MRI)	0.000		0		0	0		0		0	0
59	Cardiac Catheterization	0.000		0		0	0		0		0	0
60	Laboratory	0.000		0		0	0		0		0	0
61	PBP Clinical Laboratory Services-Program Only	0.000		0		0	0		0		0	0
62	Whole Blood & Packed Red Blood Cells	0.000		0		0	0		0		0	0
63	Blood Storing, Processing, & Trans.	0.000		0	1	0	0		0	1	0	0
64	Intravenous Therapy	0.000		0	1	0	0		0	1	0	0
65	Respiratory Therapy	0.000		0	1	0	0		0	1	0	0
66	Physical Therapy	0.000		0		0	0		0		0	0
67	Occupational Therapy	0.000		0		0	0		0		0	0
68	Speech Pathology	0.000		0		0	0		0		0	0
69	Electrocardiology	0.000		0		0	0		0		0	0
70	Electroencephalography	0.000		0		0	0		0		0	0
71	Medical Supplies Charged to Patients	0.000		0		0	0		0		0	0
72	Implantable Devices Charged to Patients	0.000		0		0	0		0		0	0
73	Drugs Charged to Patients	0.000		0		0	0		0		0	0
74	Renal Dialysis	0.000		0		0	0		0		0	0
75	ASC (Non-Distinct Part)	0.000		0		0	0		0	1	0	0
	Other Ancillary (specify)	0.000		0		0	0		0		0	0
	OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic	0.000		0		0	0		0		0	0
89	Federally Qualified Health Center	0.000		0		0	0		0		0	0
90	Clinic	0.000		0		0	0		0		0	0
91	Emergency	0.000		0		0	0		0		0	0
	Observation Beds	0.000		0		0	0		0		0	0

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	SCHEDULE C: MEDICAID MCO (MMCO),	HSN & UN	IINSURED &	DUAL-ELIGIBL	E COSTS							
	COMPUTATION OF MASSACHUSETTS MEDICAID M	ICO AND LOV	W INCOME UNC	OMPENSATED CA	RE COSTS							
									HSN & UNINSURED			TOTAL HSN &
	ARRY OF WELL BETTARD IN THE			MASS. MMCO INPATIENT COSTS			TOTAL MASS. MMCO I/P AND		INPATIENT COSTS (COL 1 x COL 7 except lines 30 -	HSN & UNINSURED CARE	HSN & UNINSURED CARE OUTPATIENT COSTS	UNINSURED CARE COSTS
	COST CENTER DESCRIPTION	HOSPITAL COST TO CHARGE RATIOS	MASS. MMCO	(COL 1 x COL 2 except lines 30 - 46)	MASS. MMCO OUTPATIENT CHARGES	MASS. MMCO OUTPATIENT COSTS (COL 1 x COL 4)	O/P COSTS (COL 3 + COL 5)	INPATIENT CHARGES	46)	OUTPATIENT CHARGES	(COL 1 x COL 9)	(COL 8 + COL 10)
		(SCH A COL 5)	INPATIENT CHARGES									
Ln No.		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
93	Other Outpatient Service (specify)	0.000		0		0	0		0		0	0
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis	0.000		0		0	0		0		0	0
95	Ambulance Services	0.000		0		0	0		0		0	0
96	Durable Medical Equipment-Rented	0.000		0		0	0		0		0	0
97	Durable Medical Equipment-Sold	0.000		0		0	0		0		0	0
98	Other Reimbursable (specify)	0.000		0		0	0		0		0	0
99	Outpatient Rehabilitation Provider (specify)	0.000		0		0	0		0		0	0
100	Intern-Resident Service (not appvd. tchnq. prqm.)	0.000		0		0	0		0		0	0
101	Home Health Agency	0.000		0		0	0		0		0	0
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition	0.000		0		0	0		0		0	0
106	Heart Acquisition	0.000		0		0	0		0		0	0
107	Liver Acquisition	0.000		0		0	0		0		0	0
108	Lung Acquisition	0.000		0		0	0		0		0	0
109	Pancreas Acquisition	0.000		0		0	0		0		0	0
110	Intestinal Acquisition	0.000		0		0	0		0		0	0
111	Islet Acquisition	0.000		0		0	0		0		0	0
112	Other Organ Acquisition (specify)	0.000		0		0	0		0		0	0
115	Ambulatory Surgical Center (Distinct Part)	0.000		0	1	0	0		0		0	0
116	Hospice	0.000		0		0	0		0		0	0
117	Other Special Purpose (specify)	0.000		0	1	0	0		0		0	0
118	SUBTOTAL (sum of lines 30-117)		0	0	0	0	0	0	0	0	0	0
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											
191	Research											
192	Physicians' Private Offices											
193	Nonpaid Workers											
194	Other Nonreimbursable (specify)											
200	Cross Foot Adjustments											
201	Negative Cost Centers											
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	SCHEDULE C. MEDICALD MCO (MMCO)				FILING DATE:	4 (0 (4 000
	SCHEDULE C: MEDICAID MCO (MMCO),	LIOOP V				1/0/1900
		PROVIDER NAME:	ersion (Interim/Final):		0	
	COMPUTATION OF MASSACHUSETTS MEDICAID M			0		1
		PROVIDER NUMBER:	0		FROM:	1/0/1900
				1	TO:	1/0/1900
	COST CENTER DESCRIPTION	DUAL ELIGIBLE INPATIENT CHARGES	DUAL ELIGIBLE INPATIENT COSTS (COL 1 x COL 12 except lines 30 - 46)	DUAL ELIGIBLE OUTPATIENT CHARGES	DUAL ELIGIBLE OUTPATIENT COSTS (COL 1 x COL 14)	TOTAL DUAL ELIGIBLE COSTS (COL 13 + COL 15)
Ln No.		(12)	(13)	(14)	(15)	(16)
30	Adults and Pediatrics (General Routine Care)		0	Ì	0	0
31	Intensive Care Unit		0		0	0
32	Coronary Care Unit		0		0	0
33	Burn Intensive Care Unit		0		0	0
34	Surgical Intensive Care Unit		0		0	0
35	Other Special Care (specify)		0		0	0
40	Subprovider IPF		0		0	0
41	Subprovider IRF		0		0	0
42	Subprovider (specify)		0		0	0
43	Nursery		0		0	0
44	Skilled Nursing Facility		0		0	0
45	Nursing Facility		0		0	0
46	Other Long Term Care		0		0	0
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		0		0	0
	Recovery Room		0		0	0
52	Labor Room and Delivery Room		0		0	0
53	Anesthesiology		0		0	0
54	Radiology-Diagnostic		0		0	0
55	Radiology-Therapeutic		0		0	0
56	Radioisotope		0		0	0
57	Computed Tomography (CT) Scan		0		0	0
58	Magnetic Resonance Imaging (MRI)		0		0	0
59	Cardiac Catheterization		0		0	0
60	Laboratory		0		0	0
61	PBP Clinical Laboratory Services-Program Only		0		0	0
62	Whole Blood & Packed Red Blood Cells		0		0	0
63	Blood Storing, Processing, & Trans.		0		0	0
64	Intravenous Therapy		0		0	0
65	Respiratory Therapy		0		0	0
66	Physical Therapy		0		0	0
67	Occupational Therapy		0		0	0
68	Speech Pathology		0		0	0
69	Electrocardiology		0	ļ	0	0
70	Electroencephalography		0	ļ	0	0
71	Medical Supplies Charged to Patients		0		0	0
72	Implantable Devices Charged to Patients		0		0	0
73	Drugs Charged to Patients		0	ļ	0	0
74	Renal Dialysis		0		0	0
75	ASC (Non-Distinct Part)		0		0	0
76	Other Ancillary (specify)		0		0	0
	OUTPATIENT SERVICE COST CENTERS		,			
88	Rural Health Clinic		0		0	0
89	Federally Qualified Health Center		0		0	0
90	Clinic		0		0	0
	Emergency		0		0	0
92	Observation Beds		0		0	0

	SCHEDULE C: MEDICAID MCO (MMCO),				FILING DATE:	1/0/1900
		UCCR V	ersion (Interim/Final):		0	
	COMPUTATION OF MASSACHUSETTS MEDICAID M		<u> </u>	0		
	COMPORATION OF MASSACIOSETTS MEDICALD M	PROVIDER NUMBER:	0		FROM:	1/0/1900
		PROVIDER NUMBER:	0			
			I	1	TO:	1/0/1900
	COST CENTER DESCRIPTION	DUAL ELIGIBLE INPATIENT CHARGES	DUAL ELIGIBLE INPATIENT COSTS (COL 1 x COL 12 except lines 30 - 46)	DUAL ELIGIBLE OUTPATIENT CHARGES	DUAL ELIGIBLE OUTPATIENT COSTS (COL 1 x COL 14)	TOTAL DUAL ELIGIBLE COSTS (COL 13 + COL 15)
Ln No.		(12)	(13)	(14)	(15)	(16)
93	Other Outpatient Service (specify)		0		0	0
	OTHER REIMBURSABLE COST CENTERS					
94	Home Program Dialysis		0		0	0
95	Ambulance Services		0		0	0
96	Durable Medical Equipment-Rented		0		0	0
97	Durable Medical Equipment-Sold		0		0	0
98	Other Reimbursable (specify)		0		0	0
99	Outpatient Rehabilitation Provider (specify)		0		0	0
100	Intern-Resident Service (not appvd. tchng. prgm.)		0		0	0
101	Home Health Agency		0		0	0
	SPECIAL PURPOSE COST CENTERS					
105	Kidney Acquisition		0		0	0
106	Heart Acquisition		0		0	0
107	Liver Acquisition		0		0	0
108	Lung Acquisition		0		0	0
109	Pancreas Acquisition		0		0	0
110	Intestinal Acquisition		0		0	0
111	Islet Acquisition		0		0	0
112	Other Organ Acquisition (specify)		0		0	0
115	Ambulatory Surgical Center (Distinct Part)		0		0	0
116	Hospice		0		0	0
117	Other Special Purpose (specify)		0		0	0
118	SUBTOTAL (sum of lines 30-117)	0	0	0	0	0
	NONREIMBURSABLE COST CENTERS					
190	Gift, Flower, Coffee Shop, & Canteen					
191	Research					
192	Physicians' Private Offices					
193	Nonpaid Workers					
194	Other Nonreimbursable (specify)					
200	Cross Foot Adjustments					
201	Negative Cost Centers					

	SCHEDULE D: UNCOMPENSATED PHYSI	CLAN COSTS											
	SCHEDULE D: UNCOMPENSATED PHYSI	CIAN COSTS										HOOD W	des de testes de la constant
												UCCR Vers	sion (Interim/Fina
	COMPUTATION OF UNCOMPENSATED PHYSICIAN	COSTS	.								PROVIDER NAME:		
											PROVIDER NUMBER:	•	0
	COST CENTER DESCRIPTION	PROFESSIONAL COMPONENT OF PHYSICIAN COSTS (FROM 2552 WKSHT A- 8-2 COL 4)	OVERHEAD COSTS RELATED TO PHYSICIAN SERVICES IF NOT INCLUDED IN COL 1 (FROM 2552 WKSHT A-8)	TOTAL PHYSICIAN COSTS (COL 1 + COL 2)	TOTAL PHYSICIAN I/P AND O/P CHARGES	PHYSICIAN COST-TO- CHARGE RATIO (COL 3 / COL 4)	- MASSHEALTH FFS I/P AND O/P PHYSICIAN CHARGES	MASSHEALTH FFS I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 6)	MASS. MMCO I/P AND O/P PHYSICIAN CHARGES	MASS. MMCO I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 8)	HSN & UNINSURED I/P AND O/P PHYSICIAN CHARGES	HSN & UNINSURED I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 10)	DUAL ELIGIBLE I/P AT O/P PHYSICIAN CHARGES
Ln No.		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
30	Adults and Pediatrics (General Routine Care)			0		0.000		0		0		0	
31	Intensive Care Unit			0		0.000		0		0		0	
32	Coronary Care Unit			0		0.000		0		0		0	
33	Burn Intensive Care Unit			0		0.000		0		0		0	
34	Surgical Intensive Care Unit			0		0.000		0		0		0	
35	Other Special Care (specify)			0		0.000		0		0		0	
	Subprovider IPF			0		0.000		0		0		0	
	Subprovider IRF			0		0.000		0		0		0	
42	Subprovider (specify)			0		0.000		0		0		0	
43	Nursery			0		0.000		0		0		0	
44	Skilled Nursing Facility			0		0.000		0		0		0	
45	Nursing Facility			0		0.000		0		0		0	
46	Other Long Term Care			0		0.000		0		0		0	
	ANCILLARY SERVICE COST CENTERS												
50	Operating Room			0		0.000		0		0		0	
	Recovery Room			0		0.000		0		0		0	
52	Labor Room and Delivery Room			0		0.000		0		0		0	
53	Anesthesiology			0		0.000		0		0		0	
54	Radiology-Diagnostic			0		0.000		0		0		0	
55	Radiology-Therapeutic			0		0.000		0		0		0	
56	Radioisotope			0		0.000		0		0		0	
57	Computed Tomography (CT) Scan			0		0.000		0		0		0	
	Magnetic Resonance Imaging (MRI)			0		0.000		0		0		0	
59	Cardiac Catheterization			0		0.000		0		0		0	
	Laboratory			0		0.000		0		0		0	
61	PBP Clinical Laboratory Services-Program Only			0		0.000		0		0		0	
62	Whole Blood & Packed Red Blood Cells			0		0.000		0		0		0	
63	Blood Storing, Processing, & Trans.			0		0.000		0		0		0	
	Intravenous Therapy			0		0.000		0		0		0	
	Respiratory Therapy			0		0.000		0		0		0	
66	Physical Therapy	ļ		0		0.000		0		0		0	
67	Occupational Therapy			0		0.000		0		0		0	
	Speech Pathology	1		0	!	0.000	!	0		0		0	
	Electrocardiology	ļ		0	ļ	0.000	ļ	0		0		0	
	Electroencephalography	ļ		0	ļ	0.000	ļ	0		0		0	
	Medical Supplies Charged to Patients	1		0	!	0.000	!	0		0		0	
	Implantable Devices Charged to Patients	1		0	!	0.000	!	0		0		0	
	Drugs Charged to Patients	1		0	 	0.000	 	0		0		0	
	Renal Dialysis	-		0	-	0.000	-	0		0		0	
	ASC (Non-Distinct Part)	1		0	 	0.000	 	0		0		0	
76	Other Ancillary (specify)			0		0.000		0	L	0	L	0	
_	OUTPATIENT SERVICE COST CENTERS					ı		T	1	1			ı
88		1		0	!	0.000	!	0		0		0	-
	Federally Qualified Health Center	1		0	!	0.000	!	0		0		0	-
	Clinic			0		0.000		0		0		0	
	Emergency			0		0.000		0		0		0	
	Observation Beds	ļ		0		0.000		0		0		0	
93	Other Outpatient Service (specify)		<u> </u>	0	<u> </u>	0.000	L	0		0		0	<u> </u>
	OTHER REIMBURSABLE COST CENTERS		T .		_	T	_	T	1	T	1	T	T
	Home Program Dialysis	ļ		0		0.000		0		0		0	
95	Ambulance Services			0		0.000		0		0		0	
04	Durable Medical Equipment-Rented			0	L	0.000	L	0		0		0	<u></u>

	COLIEDULE D. LINGOMPENCATED DUVEL	OLANI GOCTO											
	SCHEDULE D: UNCOMPENSATED PHYSIC	CIAN COSTS											
												UCCR Vers	sion (Interim/Final):
С	COMPUTATION OF UNCOMPENSATED PHYSICIAN	COSTS									PROVIDER NAME:		
											PROVIDER NUMBER:		0
Ln No.	COST CENTER DESCRIPTION	PROFESSIONAL COMPONENT OF PHYSICIAN COSTS (FROM 2552 WKSHT A- 8-2 COL 4)	OVERHEAD COSTS RELATED TO PHYSICIAN SERVICES IF NOT INCLUDED IN COL 1 (FROM 2552 WKSHT A-8) (2)	TOTAL PHYSICIAN COSTS (COL 1 + COL 2) (3)	TOTAL PHYSICIAN I/P AND O/P CHARGES	PHYSICIAN COST-TO- CHARGE RATIO (COL 3 / COL 4)	MASSHEALTH FFS I/P AND O/P PHYSICIAN CHARGES (6)	MASSHEALTH FFS I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 6)	MASS. MMCO I/P AND O/P PHYSICIAN CHARGES (8)	MASS. MMCO I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 8)	HSN & UNINSURED I/P AND O/P PHYSICIAN CHARGES (10)	HSN & UNINSURED I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 10)	DUAL ELIGIBLE I/P AND O/P PHYSICIAN CHARGES (12)
		(1)	(2)		(4)		(0)		(0)		(10)	i	(12)
	urable Medical Equipment-Sold			0		0.000		0		0		0	
	Ither Reimbursable (specify)			0		0.000		0		0		0	
	utpatient Rehabilitation Provider (specify)			0		0.000		0		0		0	
	ntern-Resident Service (not appvd. tchng. prgm.)			0		0.000		0		0		0	
	ome Health Agency SPECIAL PURPOSE COST CENTERS			0	l	0.000		0	l	0		0	
-			1		l .	1	1	1	l .			l .	
	idney Acquisition			0		0.000		0		0		0	
	eart Acquisition			0		0.000		0		0		0	-
-	iver Acquisition			0		0.000		0		0		0	-
	ung Acquisition			0		0.000		0		0		0	-
	ancreas Acquisition			0		0.000		0		0		0	
	ntestinal Acquisition			0		0.000		0		0		0	
	slet Acquisition			0		0.000		0		0		0	
	other Organ Acquisition (specify)			0		0.000		0		0		0	ļ
	mbulatory Surgical Center (Distinct Part)			0		0.000		0		0		0	
116 Ho				0		0.000		0		0		0	
	other Special Purpose (specify)			0		0.000		0		0		0	<u> </u>
	SUBTOTAL (sum of lines 30-117)	0	0	0	0		0	0	0	0	0	0	0
	NONREIMBURSABLE COST CENTERS												
	ift, Flower, Coffee Shop, & Canteen												
	esearch												
-	hysicians' Private Offices												
	onpaid Workers												
194 Ot	ther Nonreimbursable (specify)												
200 Cr	ross Foot Adjustments												
201 Ne	egative Cost Centers												
1 1													

	SCHEDULE D: UNCOMPENSATED PHYSIC	FILING DATE:	1/0/1900
			0
	COMPUTATION OF UNCOMPENSATED PHYSICIAN	0	
		FROM:	1/0/1900
		TO:	1/0/1900
No.	COST CENTER DESCRIPTION	DUAL ELIGIBLE I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 12)	TOTAL UCCR PHYSICI COSTS (COL 7 + COL 9 + COL 11 + COL 13)
	Adults and Pediatrics (General Routine Care)	0	0
	Intensive Care Unit	0	0
	Coronary Care Unit	0	0
33	Burn Intensive Care Unit	0	0
34	Surgical Intensive Care Unit	0	0
35	Other Special Care (specify)	0	0
	Subprovider IPF	0	0
41	Subprovider IRF	0	0
	Subprovider (specify)	0	0
	Nursery	0	0
	Skilled Nursing Facility	0	0
45 46	Nursing Facility Other Long Term Care	0	0
40	ANCILLARY SERVICE COST CENTERS	ů	Ü
50	Operating Room	0	0
	Recovery Room	0	0
52	Labor Room and Delivery Room	0	0
53	Anesthesiology	0	0
54	Radiology-Diagnostic	0	0
55	Radiology-Therapeutic	0	0
56	Radioisotope	0	0
57	Computed Tomography (CT) Scan	0	0
	Magnetic Resonance Imaging (MRI)	0	0
	Cardiac Catheterization	0	0
	Laboratory	0	0
61	PBP Clinical Laboratory Services-Program Only	0	0
	Whole Blood & Packed Red Blood Cells Blood Storing, Processing, & Trans.	0	0
	Intravenous Therapy	0	0
65	Respiratory Therapy	0	0
	Physical Therapy	0	0
	Occupational Therapy	0	0
	Speech Pathology	0	0
69	Electrocardiology	0	0
70	Electroencephalography	0	0
71	Medical Supplies Charged to Patients	0	0
	Implantable Devices Charged to Patients	0	0
	Drugs Charged to Patients	0	0
74	Renal Dialysis	0	0
	ASC (Non-Distinct Part)	0	0
76	Other Ancillary (specify)	0	0
00	OUTPATIENT SERVICE COST CENTERS		
88	Rural Health Clinic	0	0
	Federally Qualified Health Center Clinic	0	0
		0	0
91	Emergency Observation Beds	0	0
	Other Outpatient Service (specify)	0	0
	OTHER REIMBURSABLE COST CENTERS		
94	Home Program Dialysis	0	0
95	Ambulance Services	0	0
	Durable Medical Equipment-Rented	0	0

	SCHEDULE D: UNCOMPENSATED PHYSIC	FILING DATE:	1/0/1900
			0
	COMPUTATION OF UNCOMPENSATED PHYSICIAN	0	
	COMI CTATION OF CHOOMI ENSATED FITTS TOTAL	FROM:	1/0/1900
		TO:	1/0/1900
	COST CENTER DESCRIPTION	DUAL ELIGIBLE I/P AND	TOTAL UCCR PHYSICIA
	COST CENTER DESCRIPTION	O/P PHYSICIAN COSTS (COL 5 x COL 12)	(COL 7 + COL 9 + COL 11 + COL 13)
n No.		(13)	(14)
	Durable Medical Equipment-Sold	0	0
	Other Reimbursable (specify)	0	0
	Outpatient Rehabilitation Provider (specify)	0	0
	Intern-Resident Service (not appvd. tchng. prgm.)	0	0
101	Home Health Agency	0	0
	SPECIAL PURPOSE COST CENTERS		Ī
	Kidney Acquisition	0	0
	Heart Acquisition	0	0
	Liver Acquisition	0	0
	Lung Acquisition	0	0
109	Pancreas Acquisition	0	0
110	Intestinal Acquisition	0	0
111	Islet Acquisition	0	0
112	Other Organ Acquisition (specify)	0	0
115	Ambulatory Surgical Center (Distinct Part)	0	0
116	Hospice	0	0
117	Other Special Purpose (specify)	0	0
118	SUBTOTAL (sum of lines 30-117)	0	0
	NONREIMBURSABLE COST CENTERS		
190	Gift, Flower, Coffee Shop, & Canteen		
191	Research		
192	Physicians' Private Offices		
193	Nonpaid Workers		
194	Other Nonreimbursable (specify)		
	Cross Foot Adjustments		
	Negative Cost Centers		

SCHEDULE E: SAFETY NET HEALTH CARE SYSTEM (SNHCS) EXPENDITURES

			FILING DATE:	1/0/1900
		UCCR VERSION (INTERIM/FINAL)	-	0
	SUMMARY OF SNHCS EXPENDITURES	PROVIDER NAME:		0
		PROVIDER NUMBER:		0
		REPORTING PERIOD:	FROM:	1/0/1900
			TO:	1/0/1900
Ln No.	SYSTEM FINANCIAL REQUIREMENTS DESCRIPTION	TOTAL SYSTEM EXPENDITURE (1)	MEDICAID-ELIGIBLE / HSN & UNINSURED PAYER MIX PROPORTION (2)	MEDICAID / HSN & UNINSURED SHARE OF SYSTEM EXPENDITURE (COL 1 x COL 2) (3)
1				0
2				0
3				0
4				0
5				0
6				0
7				0
8				0
9				0
10				0
11				0
12				0
13				0
14				0
15				0
	TOTAL	0		0

Safety Net Care Cost Ratio #DIV/0!

Ln. No.	SYSTEM FINANCIAL REQUIREMENTS, ADDITIONAL NARRATIVE DESCRIPTION:
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
12	
13	
14	
15	

	SCHEDULE F: MEDICAID AND UNINSURED	REVENUE						
					Filing Date:	1/0/1900		
				UCCR Vei	rsion (Interim/Final):		0	
			PROVIDER N.		,			
				PROVIDER NUMBER:		0		
						0 REPORTING PERIOD: FROM: 1/0/1900		1/0/1900
						NEI GRANIGA ERROD.	TO:	
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
Ln No.	REVENUE DESCRIPTION	MEDICAID FFS INPATIENT	MEDICAID FFS OUTPATIENT	MMCO INPATIENT	MMCO OUTPATIENT	HSN & UNINSURED (Inpatient & Outpatient)	DUAL ELIGIBLE (Inpatient & Outpatient)	TOTAL REVENUE (SUM of COL 1 through 6)
EII IVO.	HOSPITAL AND CLINIC REVENUE							
1	Payer Medical Claims Revenue							0
2	Payer Performance or Incentive Payments							0
3	Supplemental Payment (specify)							0
4	Supplemental Payment (specify)							0
5	Supplemental Payment (specify)							0
6	Medicare Revenue							0
7	Third Party and Self Pay Revenue							0
8	Other Revenue (specify)							0
9	SUBTOTAL: HOSPITAL AND CLINIC (Sum Line 1-8)	0	0	0	0	0	0	0
	PHYSICIAN REVENUE							
10	Payer Medical Claims Revenue							0
11	Payer Performance Payment Revenue							0
12	Supplemental Payment (specify)							0
13	Medicare Revenue							0
14	Third Party and Self Pay Revenue							0
15	Other Revenue (specify)							0
16	SUBTOTAL: PHYSICIAN (Sum Line 10-15)	0	0	0	0	0	0	0
17	TOTAL REVENUE (Line 9 + Line 16)	0	0	0	0	0	0	0
18	TOTAL COST LIMIT PROTOCOL REVENUE Line 17 - Line 11 - Line 2)	0	0	0	0	0	0	0

Filing Date:	1/0/1900					
UCCR Version		0				
PROVIDER NAME:	0					
PROVIDER NUMBER(S):		0				
REPORTING PERIOD:	FROM:	1/0/1900				
	TO:	1/0/1900				

Use this space to provide any additional information relevant to this filing:

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